IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 39084-I

June 26, 2012

Ms. Megan Johnson, Manager
Bickford Cottage of Marion
1100 Linden Drive
Marion, IA 52302

RE: I. Final Complaint/Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Johnson:

I. Final Complaint/Incident Investigation Report – Bickford Cottage of Marion, Marion, IA

Enclosed is the **Final Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiencies in the area(s) of: Staffing. **Bickford Cottage of Marion** ("Program") is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on June 22, 2012, has been reviewed and will constitute the final POC related to the on-site visit of May 24, 2012.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Megan Johnson, Manager
Bickford Cottage of Marion
1100 Linden Drive
Marion, Iowa 52302

Complaint/Incident Intake #:

39084-I

Date of Complaint/Incident Investigation:

May 24, 2012

Monitor(s):

Maribeth Freland RN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	19
Number of tenants with cognitive disorder:	10
Total Population of Program at time of on-site	29

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	36

Program History – The program received regulatory insufficiencies in the areas of Staffing and Medications.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Staffing

Complaint/Incident Allegation: It was reported a tenant exhibiting dementia wandered away while unsupervised during an off-site activity.

- Monitoring Observation: Tenant #1, an 80 year old, was admitted to the program on 2-24-09 with diagnoses of Dementia with Delusions, Aortic Stenosis, Hypertension (HTN), and Thrombophlebitis of Lower Extremities. Tenant #1 scored 5 on the Global Deterioration Scale (GDS) completed on 3-7-12, which indicated moderately severe cognitive decline. Tenant #1 resided in the general population area that was dementia specific by definition.

  The evaluation of Tenant #1's health and functional status, dated 3-7-12, indicated Tenant #1 required set up and assistance with bathing, grooming and dressing and stand by assistance with incontinence care. Tenant #1 required stand by assistance while ambulating and daily escort to and from meals and activities to ensure safety.

  Tenant #1's service plan, dated 3-7-12, documented Tenant #1 required daily escort to and from meals and activities to ensure safety. The service plan indicated Tenant #1 frequently asked others when he/she was going home and required daily reminders of usual routine. The service plan directed staff members to tell Tenant #1 the doctor wanted Tenant #1 to stay with staff members for awhile. The service plan indicated Tenant #1 wore a Home Free watch due to previous elopement attempts.

Tenant #1's clinical record documented Tenant #1 eloped from the program without staff member knowledge on 12-29-11 at 1:40 p.m., exiting the building with visitors. The incident report indicated staff members observed a parked car loading passengers at the front entrance of the building. Staff members observed the car leave the drive, noting Tenant #1 remained standing on the sidewalk. Staff members exited the building to approach Tenant #1. When staff members reached Tenant #1, he/she was attempting to get into a car parked in the program's parking lot. Tenant #1 returned with staff members into the building without incident. Tenant #1 had no previous exit seeking behaviors or prior elopements.

The program's doors leading to the outside were alarmed, requiring a code to be input in order to open the doors without sounding an audible alarm. Staff members did not hear the audible alarm prior to Tenant #1's elopement. The program immediately applied a Home Free watch to Tenant #1's left wrist. The Home Free system sends a message to staff member pagers and the program telephones whenever an exit door was opened and a tenant wearing a Home Free watch was in the immediate vicinity of the door way to alert staff members to a potential for elopement. The program also placed signage at the front entrance to inform visitors to ensure they do not assist tenants out of the building without first notifying staff members. The program reported the elopement to the Department of Inspections and Appeals as required. Tenant #1 had no further documented elopements from the program with the use of the Home Free system.

The program's policy, dated 4-09 and titled Unwitnessed Door Alarm, directed staff members to immediately check pagers to determine the type of door alarm if no staff member witnessed the event surrounding the alarm, perform a visual search inside and outside the door area, summon assistance if no tenant was found during the search and account for all tenants. The Manager reported staff members are instructed to perform a "head count" to assure all tenants were accounted for and place the documentation in a folder kept in the nursing office. The monitor requested documentation indicating the head count had been completed following Tenant #1's 12-29-11 elopement that had been unwitnessed by staff members. The Manager reported she was unable to find such documentation.

Tenant #3, a an 88 year old, was admitted to the program on 9-8-10 with diagnoses of Valvular Heart Disease, Coronary Artery Disease, Arthritis, Osteoporosis and HTN. Tenant #3 scored 4 on the GDS completed on 3-28-12, which indicated moderate cognitive decline. Tenant #3 resided in the general population area that was dementia specific by definition.

The evaluation of Tenant #3's health and functional status, dated 3-28-12, indicated Tenant #3 required set up and assistance with bathing and dressing and was independent with grooming, toileting, transfers and ambulation using a walker.

Tenant #3's service plan, dated 3-29-12, documented Tenant #3 frequently packed his/her belongings and brought the items to the general areas of the program. Tenant #3 told others his/her parents or spouse were coming to take Tenant #3 home. The service plan indicated Tenant #3 wore a Home Free watch due to previous exit seeking behaviors.

Tenant #3's clinical record documented Tenant #3 eloped from the program without staff member knowledge on 5-4-12 at 2:45 p.m., exiting the building while unattended out of a service door near the kitchen. The incident report indicated the only witness to Tenant #3's exit from the building was Tenant #5. Tenant #5 was cognitively intact and resided in the general population area. The report indicated Tenant #3 exited the building, setting off an audible alarm. Staff members responded, looking for which door had alarmed. Tenant #5 told staff members Tenant #3 had exited the door near the kitchen. Staff members went outside, finding Tenant #3 on the sidewalk. Tenant #3 reported he/she was looking for his/her car. During interview, Tenant #5 reported Tenant #3 frequently told others that Tenant #3 was going home. Tenant #3 was in the common dining room area and Tenant #5 was in the common living room area on 5-4-12 around 2:45 p.m. Tenant #5 reported Tenant #3 ambulated down a hallway to a service door near the kitchen and exited through the door. Tenant #5 reported no staff members were in the immediate area. A staff member soon entered the area and Tenant #5 told the staff member Tenant #3 went out the door. Staff members immediately went out the door and returned with Tenant #3. Tenant #5 reported staff members told him/her that Tenant #3 had gotten down the sidewalk and was starting down the street. According to the State Climatologist, it was 76 degrees at 2:52 p.m. on 5-4-12 and mostly clear skies with winds from the east at 8 mph. Tenant #3 was dressed appropriately for the weather.

The program's doors leading to the outside were alarmed, requiring a code to be input in order to open the doors without sounding an audible alarm. Staff members heard the audible alarm following Tenant #3's elopement. The Home Free system also alerted staff members via pagers of the elopement. Staff members responded immediately and returned Tenant #3 to the program without incident. The program reported the elopement to the Department of Inspections and Appeals as required.

The monitor requested documentation indicating the head count had been completed following Tenant #3's 5-4-12 elopement that had been unwitnessed by staff members. The Manager reported she was unable to find such documentation.

The program did not maintain documentation of the head count following both Tenant #1 and Tenant #3's unwitnessed elopements, as required by the program's policy.

On 5-6-12 at approximately 3:30 p.m., Staff #1, the program's Activity Coordinator, transported Tenant #1 and Tenant #3 and two other cognitively impaired tenants, Tenant #2 and Tenant #4, to a music and bell choir concert at a church in Marion. During the outing, Staff #1 left all four tenants unsupervised for an unspecified period of time to retrieve the two tenants' walkers from the back area of the church. While unsupervised, Tenant #1 exited the church building without staff member supervision and was missing for approximately 25 to 30 minutes.

Tenant #1 presumably stood and ambulated down a side aisle to the front altar area. Tenant #1 exited through double doors into a foyer area and through another set of double doors exiting the church via a side exit door. The side door exited to a platform with five steps down to a sidewalk. The doors faced a residential street with a posted speed limit of 25 miles per hour (mph). A visitor attending the concert

assisted Tenant #1 down a flight of stairs and into his vehicle as Tenant #1 reported his/her ride had left and expressed needing a ride home. Tenant #1 was unable to tell the visitor where he/she lived so the visitor contacted the police department without ever leaving the church area.

On 5-24-12 at approximately 11:00 a.m., the monitor visited the church in Marion while accompanied by Staff #1 and the program's manager. The church was located approximately five minutes from the program. The front entrance of the church entered into a foyer then through a maze of hallways to reach the sanctuary. The area immediately outside of the sanctuary had three coat racks. The sanctuary had a main middle aisle entrance with double doors leading directly into the sanctuary. The main entrance was surrounded by solid walls on each side, barring visualization of the sanctuary. Two other entrances into the sanctuary were located at each end of the solid walls. Both of these doors were located around the corner and perpendicular to the solid wall. Once around the corner, only the back row of pews of the middle of the sanctuary could be visualized from the doorways.

The sanctuary contained four rows of pews separated by three aisles. The outside rows of pews were nestled up to the walls and required entrance and exit from the outside two aisles. The main aisle separated the two middle rows of pews. Another exit was located at the front of sanctuary and at the left side of the altar. The set of double doors exited into a foyer area and another set of double doors exited out through the side of the church.

Staff #1 reported transporting Tenants #1, #2, #3 and #4 to the church at approximately 3:30 p.m. on 5-6-12. Staff #1 reported parking in the church's front lot in a handicapped spot and escorted all four tenants into the church's front entrance. Staff #1 reported Tenants #1 and #2 ambulated independently beside Staff #1 and Tenants #3 and #4 used walkers and ambulated along with the group. Staff #1 lead all four tenants to the sanctuary area, entered the sanctuary through the middle aisle doors and seated all four tenants in row five or six from the front of the church and in the left middle row of pews. Staff #1 turned and exited the sanctuary through the same door with Tenant #3 and #4's walkers and placed the walkers underneath a coat rack. The coat rack where Staff #1 placed the walkers was to the right of the middle aisle door. The coat rack was directly in front of a solid wall which obstructed all view of the sanctuary area. Staff #1 returned to the sanctuary and sat with all four tenants throughout the program.

At approximately 5:00 p.m., Staff #1 stood and exited the sanctuary to retrieve the two walkers. Staff #1 left all four tenants seated in the pew unsupervised. Staff #1 reported many people had attended the concert. When Staff #1 reentered the sanctuary, people had begun rising to leave. She traveled down the main aisle toward the pew where she had left the tenants. When she again visualized the tenants she noted Tenants #2, #3 and #4 standing but had not yet exited the pew and Tenant #1 was no longer with the group. Staff #1 asked Tenant #2, #3 and #4 where Tenant #1 was. Tenant #4 reported Tenant #1 "went the other way". Staff #1 attempted to visualize Tenant #1 to the left of the sanctuary and was unable to locate Tenant #1. Staff #1 lead Tenants #2, #3 and #4 out the middle aisle of the sanctuary, calling out Tenant #1's name in an attempt to locate him/her. Staff #1 lead the other three tenants to the front area of the church and seated them on a bench inside the entrance

foyer. Staff #1 left Tenants #2, #3 and #4 under the supervision of several church ladies and went off in search of Tenant #1. Staff #1 sought the assistance of church members and other visitors in locating Tenant #1. After approximately 25 minutes, Staff #1 had been unable to locate Tenant #1 within the church. Staff #1 returned to the bench where the other three tenants were being supervised by the church ladies. Staff #1 called the program to report the missing tenant and a church member contacted the police department to report Tenant #1 was missing. A few minutes later, a visitor pulled up to the front entrance of the church with Tenant #1 inside of his vehicle. The visitor reported he had assisted Tenant #1 down the stairs and into his vehicle as Tenant #1 reported being left alone and needed a ride home. After Tenant #1 was unable to tell the visitor where his/her home was, the visitor contacted the police department who instructed him to drive to the main entrance of the church as those responsible were awaiting there.

Tenant #1 was unharmed and unaware he/she had been missing. According to the State Climatologist, it was 75 degrees at 5:52 p.m. on 5-6-12 and mostly clear skies with winds from the east at 9 mph. Tenant #1 was dressed appropriately for the weather.

The program had a policy, dated 4-09 and titled Missing Resident, which gave procedures for staff members to follow should a tenant be missing on-site. The program had no policy in place related to off-site activities prior to the incident on 5-6-12; however, the program put a policy in place directing a tenant/staff member ratio for all future off-site activities to be one staff member for every two tenants who have a GDS score of 4 or greater.

Tenant #1 and Tenant #3 were cognitively impaired and had a history of elopement attempts and exhibited exit seeking behaviors prior to the 5-6-12 off-site outing. Tenants #2 and #4 each were cognitively impaired; however, neither Tenant #2 nor Tenant #4 had a history of elopement or exit seeking behaviors.

Staff #1 left four cognitively impaired tenants unsupervised for an unspecified amount of time twice during the church outing. Tenant #1's service plan addressed Tenant #1's frequent requests to "go home" and indicated Tenant #1 wore a Home Free watch due to a previous elopement attempt. The service plan indicated Tenant #1 required staff member escort to and from all meals and activities to ensure safety. Staff #1 left Tenant #1 unsupervised twice during the outing on 5-6-12, resulting in Tenant #1 leaving the church with a stranger. Tenant #1 was missing for approximately 30 minutes. Tenant #3's service plan addressed Tenant #3's frequent exit seeking behaviors and indicated Tenant #3 wore a Home Free watch due to these behaviors. Tenant #3 eloped from the program on 5-4-12 without staff member knowledge. Two days later, Staff #1 left Tenant #3 unsupervised twice during a church outing despite Tenant #3's recent elopement attempt.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481- 67.9(1))

- Regulatory Insufficiency: In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or

dementia shall follow a system, program or written staff procedures to address how the program will respond to the emergency needs of the tenant(s). (IAC r. 481-69.29(2))